Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

South Austin Surgery Center
4207 James Casey #203
Austin TX 78745

MFDR Tracking #: M4-06-4770-01

DW
Injure
Da

Respondent Name and Box #:

OLD REPUBLIC INSURANCE CO
Rep Box # 42

Empl
Insurance

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "implants are payable at cost"

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $411.08
3. CMS 1500s
4. EOB's
5. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: No position summary submitted

Principal Documentation:

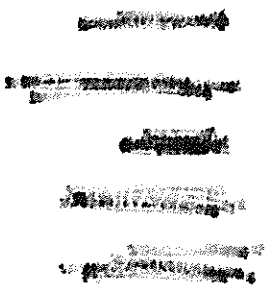
1. No response submitted

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
7/14/05	99070 (See Calculations Below)	97, W4, 857-999, 900	1	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective March 10, 2005, set out the reimbursement guidelines



1. Code 99070, for date of service 7/14/05 was denied with reduction codes "97 – Payment is included in the allowance for another service/procedure. $0.00," "W4 – No additional reimbursement allowed after review of appeal/reconsideration," 857-999 – Procedure included another code billed on same date of service. $0.00" and "900 – Based on further review, no additional allowance is warranted." Per 28 Texas Administrative Code Section. §134.402, code 99070 is not inclusive to the procedure performed on this date of service. However, code 99070, is an inappropriate code when billing for implantables associated with an ASC and is reserved for use in association with an office visit. Per 28 Texas Administrative Code Section. §134.402, implantables are to be billed using HCPC codes. Therefore, no reimbursement is recommended for this date of service in dispute.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §134.1,
28 Texas Administrative Code §134.402
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	James Schneider	2/22/08

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.